

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

32891  
Do not use this space.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

59  
1  
2

1. PLACE OF DEATH <sup>2</sup>  
 (a) County Dunklin Registration District No. 508  
 (b) Township Lehullecotte Primary Registration District No. 3026  
 (c) City Lehullecotte (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Norma M. Robbins  
 (a) Residence, No. Charles M St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April-27-38

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>5</u>	<u>4</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as saw mill, bank, etc. -

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson Township

FATHER

13. NAME French M Robbins

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelton Mo

MOTHER

15. MAIDEN NAME Altha Leumley

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jamestown Mo

17. INFORMANT (ADDRESS) French Robbins  
Sanford M

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Pleasant DATE Oct 2 - 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James Gordon  
Lehullecotte Mo

20. FILED 10-2-39 W McMan, M.D.  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct-1-1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 26 1939 to Sept 30 1939  
 I last saw her alive on Sept 30 1939. Death is said to have occurred on the date stated above, at 7:00 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Sept 26 1939  
Gastric-Enteritis  
Malnutrition  
 Date of onset \_\_\_\_\_

Other contributory causes of importance: Malnutrition

Name of operation None Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical Was there an Autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? X Date of injury X, 1939.  
 Where did injury occur? X (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. ✓

Manner of injury X  
 Nature of injury X

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify \_\_\_\_\_  
 (Signed) W H Danner, M.D.  
 (Address) Lehullecotte Mo

RECEIVED

District Health Officer No. 111

District File Number 1239-1321

Date Filed OCT 10 1939

---

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*James D Gordon*

Licensed Embalmer No. 1870

P. O. Address Chillicothe, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**